STATE OF CONNECTICUT
BOARD OF EXAMINERS FOR NURSING

Department of Public Health

vs.

Kathleen Waido, RN, Lic. No. E56641
Respondent

Petition No. 2004-1027-010-095

MEMORANDUM OF DECISION

Procedural Background

The Board of Examiners for Nursing (hereinafter "the Board") was presented by the Department of Public Health (hereinafter "the Department") with a Statement of Charges dated July 28, 2005. Dept. Exh. 1. The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Kathleen Waido (hereinafter "respondent") which would subject respondent's registered nurse license to disciplinary action pursuant to *Conn. Gen. Stat.* §§ 19a-17 and 20-99(b).

The Board issued a Notice of Hearing dated August 3, 2005, scheduling a hearing for December 7, 2005. Dept. Exh. 1.

Respondent was provided notice of the hearing and charges against her. The Notice of Hearing and Statement of Charges were delivered by certified mail to respondent's attorney. Dept. Exh. 1.

The hearing took place on December 7, 2005, in Room 1-D, Legislative Office Building, Capitol Avenue, Hartford, Connecticut.

At the commencement of the hearing, respondent's attorney withdrew his representation of respondent and respondent elected to proceed with the hearing without representation. Transcript, December 7, 2005, pp. 2-3.

Respondent orally answered the Statement of Charges. Transcript, December 7, 2005, pp. 10-14.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

Findings of Fact

Based on the testimony given and the exhibits offered into evidence, the Board makes the following Findings of Fact:

1. Respondent was issued registered nurse license number E56641 on July 1, 1994. Respondent was the holder of said license at all times referenced in the Statement of Charges. Dept. Exh. 1-tab #3; Transcript, p. 10.

2. At all times referenced in the Statement of Charges, respondent was employed as the Supervisor of Assisted Living Services for Crossroads Place, an assisted living facility in Waterford, Connecticut. Transcript, pp. 10-11.

3. On or about June 1, 2004, resident N.M., who resided at Crossroads Place, was experiencing shortness of breath and pain. Transcript, pp. 10-11.

4. On or about June 1, 2004, respondent requested that resident N.M's physician write two prescriptions, one for morphine liquid concentrate for shortness of breath and another for oxycodone for pain. Both medications are schedule II narcotic controlled substances. Transcript, p. 11.

5. On or about June 1, 2004, respondent went to the office of N.M's primary care physician and picked up the prescription forms for 120ccs of morphine sulfate 10mg/5ml (morphine liquid concentrate) and thirty (30) oxycodone 5mg tablets. Transcript, p. 11.

6. On or about June 1, 2004, after picking the prescription forms for the morphine liquid concentrate and the oxycodone, respondent proceeded to The Medicine Shoppe, New London, Connecticut where the prescriptions were filled. Transcript, pp. 11-12.

7. On or about June 1, 2004, respondent returned to Crossroads Place with the filled prescriptions. Respondent placed the morphine liquid concentrate in a locked drawer in N.M's room and placed the oxycodone in an unsecured drawer in her desk. Transcript, p. 12.

8. On or about June 1, 2004, respondent failed to document the physician orders for the morphine liquid concentrate and the oxycodone. On June 2, 2004, respondent documented the receipt of the morphine liquid concentrate order in the nurse progress notes. Dept. Exh. 1-tab 2, pp. 16, 18.

9. Respondent failed to document in N. M's medical record that she had obtained a physician order for oxycodone and that she had filled the order. Transcript, p. 13.

10. On or about June 1, 2004, respondent failed to completely, properly and/or accurately document medical records. Transcript, p. 14.

11. On or about June 2, 2004, respondent gave a dose of morphine liquid concentrate to N.M. Respondent failed to document the administration of the morphine liquid concentrate on the medication administration record but did document the administration in the nurse progress notes. Dept. Exh. 1-tab 2, pp. 16 -17; Transcript, p. 131-132, 136-137, 145.

12. On or about June 7, 2004, respondent was suspended from her position with Crossroads Place for unprofessional conduct related to lack of emotional control with patients and families. On or about June 10, 2004 respondent's employment at Crossroads Place was terminated. Transcript, pp. 13-14.

13. From June 1, 2004 through June 10, 2004, respondent failed to store the oxycodone for N.M. in a secure location. Transcript, p. 14.

14. On or after June 10, 2004 nursing staff discovered that the prescription container for N.M's oxycodone that was stored in respondent's desk drawer contained only 18 of 30 tablets. Transcript, p. 14.

Conclusions of Law and Discussion

In consideration of the above Findings of Fact, the following conclusions are rendered:

Kathleen Waido held a valid registered nurse license in the State of Connecticut at all times referenced in the Statement of Charges.

The Notice of Hearing and Statement of Charges provided sufficient legal notice as mandated by *Conn. Gen. Stat.* §§ 4-177(a) and (b), and 4-182(c). The hearing was held in accordance with *Conn. Gen. Stat.* Chapters 54 and 368a as well as §§ 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies.

The Notice of Hearing, Statement of Charges, and the hearing process provided respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of his license as required by *Conn. Gen. Stat.* § 4-182(c).

The Department bears the burden of proof by a preponderance of the evidence in this matter.

PARAGRAPH 1 of the Statement of Charges alleges that respondent is and has been the holder of registered nurse license number E56641 at all times referenced in the Statement of Charges.

PARAGRAPH 2 of the Statement of Charges alleges that at all times referenced in the Statement of Charges, respondent was employed as the Supervisor of Assisted Living Services for Crossroads Place, an assisted living facility in Waterford, Connecticut.

PARAGRAPH 3 of the Statement of Charges alleges on or about June 1, 2004, resident N.M., who resided at Crossroads Place, was experiencing shortness of breath and pain.

PARAGRAPH 4 of the Statement of Charges alleges on or about June 1, 2004, respondent requested that resident N.M's physician write two prescriptions, one for morphine liquid concentrate for shortness of breath and another for oxycodone for pain. Both medications are schedule II narcotic controlled substances.

PARAGRAPH 5 of the Statement of Charges alleges on or about June 1, 2004, respondent went to the office of N.M's primary care physician and picked up the prescription forms for 120ccs of morphine sulfate 10mg/5ml (morphine liquid concentrate) and thirty (30) oxycodone 5mg tablets.

PARAGRAPH 6 of the Statement of Charges alleges on or about June 1, 2004, after picking the prescription forms for the morphine liquid concentrate and the oxycodone, respondent proceeded to The Medicine Shoppe, New London, Connecticut where the prescriptions were filled.

PARAGRAPH 7 of the Statement of Charges alleges on or about June 1, 2004, respondent returned to Crossroads Place with the filled prescriptions. Respondent placed the morphine liquid concentrate in a locked drawer in N.M's room and placed the oxycodone in an unsecured drawer in her desk.

PARAGRAPH 8 of the Statement of Charges alleges on or about June 1, 2004, respondent gave a dose of morphine liquid concentrate to N.M.

PARAGRAPH 9 of the Statement of Charges alleges on or about June 1, 2004, respondent failed to document:

a. in either the nursing notes and/or the Medication and Treatment Record (MAR) that she had administered the morphine liquid concentrate to NM; and/or ,
b. the orders for morphine liquid concentrate and the oxycodone

PARAGRAPH 10 of the Statement of Charges alleges on or about June 2, 2004, respondent administered morphine liquid concentrate to N.M. Respondent documented in the nursing notes that she had administered the morphine liquid concentrate and recorded the new order for morphine liquid concentrate. She failed to document that she administered the morphine liquid concentrate on the MAR.

PARAGRAPH 11 of the Statement of Charges alleges that at no time did respondent document in N. M's medical record that she had obtained the physician's order for oxycodone and that she had filled that order.

PARAGRAPH 12 of the Statement of Charges alleges on or about June 7, 2004, respondent was suspended from her position with Crossroads Place for unprofessional conduct related to lack of emotional control with patients and families. On or about June 10, 2004 Crossroads Place terminated respondent's employment.

PARAGRAPH 13 of the Statement of Charges alleges from June 1, 2004 through June 10, 2004, respondent failed to store the oxycodone in a secure location.

PARAGRAPH 14 of the Statement of Charges alleges on or after June 10, 2004, while cleaning out respondent's desk, nursing staff discovered the prescription container in respondent's desk drawer for N.M's oxycodone. There were only 18 tablets remaining in the container.

PARAGRAPH 15 of the Statement of Charges alleges on and/or after June 1, 2004, respondent:

a. diverted oxycodone
b. failed to completely, properly and/or accurately document medical records; and/or,
c. falsified one or more Controlled Substance Receipt Records.

Respondent admits the allegations in paragraphs 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 14 and 15b. As to paragraph 8, respondent admits giving a dose of morphine liquid concentrate to patient N.M. on or about June 1, 2004, she does not admit that this occurred specifically on June 1, 2004. Respondent denies the allegations in paragraphs 9, 10, 15a and 15c. Transcript, December 7, 2005, pp. 10-14, 150.

The General Statutes of Connecticut § 20-99 provides in relevant part:

> (a) The Board of Examiners for Nursing shall have jurisdiction to hear all charges of conduct which fails to conform to the accepted standards of the nursing profession brought against persons licensed to practice nursing. After holding a hearing . . said board, if it finds such person to be guilty, may revoke or suspend his or her license or take any of the actions set forth in section 19a-17. . . .
> (b) Conduct which fails to conform to the accepted standards of the nursing profession includes, but is not limited to, the following: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions . . . (5) abuse or excessive use of drugs, including alcohol, narcotics or chemicals . . . (7) willful falsification of entries in any hospital, patient or other record pertaining to drugs, the result of which are detrimental to the health of a patient . . . .

Based on respondent's admissions and testimony and a review of the documents presented, the Board concludes that the allegations in Paragraphs 1, 2, 3, 4, 5, 6, 7, 9b, 10, 11, 12, 13, 14 and 15b of the Statement of Charges are proven by a preponderance of the evidence.

With regard to allegations in Paragraphs 8, 9a, 15a and 15c, the Board concludes that the Department failed to present sufficient evidence to prove these charges. Therefore, these allegations are dismissed.

As to paragraph 10, the Boards finds that although respondent failed to document the June 2, 2004 administration of morphine liquid concentrate on patient N.M's medication administration record (MAR) she did properly document the administration in the nurse progress notes. The evidence presented suggests that the order for the morphine liquid concentrate had not been transcribed to the MAR by staff and therefore was not available to be properly documented by respondent at the time of administration. The Board concludes that respondent's conduct as alleged in paragraph 10 does not rise to the level to warrant disciplinary action and is, therefore, dismissed.

The Board concludes that respondent's conduct as alleged in Paragraphs 9b, 11, 12, 13, and 15b constitutes grounds for disciplinary action pursuant to *Conn. Gen. Stat.* §§20-99(b)(2) and 19a-17.

Order

Pursuant to its authority under *Conn. Gen. Stat.* §§ 19a-17 and 20-99, the Board of Examiners for Nursing hereby orders the following:

1. That for Paragraphs 9b, 11, 12, 13, and 15b of the Statement of Charges, respondent is assessed a civil penalty in the amount of five hundred dollars ($500.00).
   A. The $500.00 civil penalty is payable on or before August 1, 2006.
   B. Payment of the civil penalty shall be made by certified check payable to "Treasurer, State of Connecticut" and shall be sent to:

Bonnie Pinkerton, RN, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
Board of Examiners For Nursing
410 Capitol Avenue, MS #12HSR
P. O. Box 340308
Hartford CT 06134-0308

2. This Memorandum of Decision becomes effective, on the date signed by the Board.

The Board of Examiners for Nursing hereby informs respondent, Kathleen Waido, and the Department of Public Health of the State of Connecticut of this decision.

Dated at Hartford, Connecticut this 21st day of June 2006.

BOARD OF EXAMINERS FOR NURSING

By _____